DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-07

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 418

7. FEDERAL BUDGET IMPACT:
a. FFY (2003) $ 000.00
b. FFY (2004) $ 000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Pages 20.21 and 20.21.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Page 20.21

10. SUBJECT OF AMENDMENT:
Hospice Reimbursement Methodology

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mike Robinson

13. TYPED NAME: Mike Robinson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 12/12/02

16. RETURN TO:
Frances McGraw
Eligibility Policy Branch
Department for Medicaid Services
275 East Main Street 6W-C
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 12, 2002

18. DATE APPROVED:
March 11, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Rhonda R. Cottrell

21. TYPED NAME:
Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

XXII. Hospice Care

A. General Reimbursement

Reimbursement for hospice care will be made at one of four predetermined rates for each day in which a recipient is under the care of the hospice. The daily rate is applicable to the type and intensity of services furnished to the recipient for that day. There are four levels of care into which each day of care is classified:

1. Routine Homecare
2. Continuous Homecare
3. Inpatient Respite Care
4. General Inpatient Care

The Medicaid hospice rates are set prospectively by Centers for Medicare and Medicaid Services, based on the methodology used in setting Medicare hospice rates and adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register.

B. Reimbursement for Room and Board

Hospice is reimbursed a per diem amount to cover room and board, for those recipients who reside in a nursing facility. The state shall reimburse ninety five percent (95%) of the nursing facility's Medicaid per diem to the hospice provider, to cover the expenses of the room and board provided to the hospice patient who occupies a Medicaid certified bed in a nursing facility.

The hospice provider shall have a contract with the nursing facility stipulating that:

1. Room and board shall be provided by the nursing facility for the hospice resident;
2. The rate the nursing facility will charge the hospice provider for room and board furnished to the Medicaid hospice resident; and
3. The hospice is fully responsible for the professional management of the Medicaid hospice patient's care.

C. Limitation on Payments for Inpatient Care

1. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed twenty percent (20%) of the total days for which these patients have elected hospice.
2. At the end of the cap period, Medicaid will calculate a limitation on payment for inpatient care (general or respite) to ensure payment is not made in excess of twenty percent (20%) of the total number of days of hospice care furnished to Medicaid patients.
3. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than twenty percent (20%) of the total days of hospice care to Medicaid patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount.

D. Monitoring of Reimbursement

The Department for Medicaid Services will perform a desk audit on each hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.